

2139 **CERTIFICATE OF DEATH**

Reg. Dist. No. 02133 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>St. Marys</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St. Marys</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Leonardtwn</b>		<b>13 hrs.</b>		TOWN <b>Leonardtwn</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St. Marys Hospital</b>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <b>Infant Girl Aud</b>				4. DATE OF DEATH <b>2/7/1956</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>		8. DATE OF BIRTH <b>2/6/56</b>	
9. AGE last birthday <b>ys.</b>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days		Hours Min.		<b>13</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas S. Aud</b>				14. MOTHER'S MAIDEN NAME <b>Rose T. Clair</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT & ADDRESS <b>Thomas A. Aud - Leonardtown, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
7544 IMMEDIATE CAUSE (A) <b>congenital heart disease</b>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Feb 6, 1956</b> , to <b>Feb 7, 1956</b> , that I last saw the deceased alive on <b>Feb 6, 1956</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.							
SIGNATURE <b>PJ Bean</b>		M.D. <b>Great Mills Md</b>		DATE SIGNED <b>2/7/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>2/7/56</b>		NAME OF CEMETERY OR CREMATORY <b>Holy Face Cemetery</b>		LOCATION (City, town, or county) <b>Great Mills, Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>PJ Bean</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Robinson</b>		ADDRESS <b>Leonardtwn, Md.</b>	
DATE <b>Feb 7/56</b>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2078213333

# CERTIFICATE OF DEATH

See, Sec. 100

1. DEATH RECORDING NUMBER OF DECEASED

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF DEATH

5. SEX

6. RACE

7. AGE

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. NO.

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CLERK

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF SHERIFF

20. SIGNATURE OF CORONER

21. SIGNATURE OF DISTRICT ATTORNEY

22. SIGNATURE OF COUNTY CLERK

23. SIGNATURE OF TOWNSHIP CLERK

24. SIGNATURE OF VILLAGE CLERK

BUREAU V. S.

FEB 9 1956

RECEIVED

RECEIVED

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. A copy of this certificate is to be sent to the local health officer of the jurisdiction in which the death occurred. The local health officer is to file a copy of this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland. The local health officer is also to file a copy of this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland. The local health officer is also to file a copy of this certificate in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

2140

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02134  
Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>St Mary's</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>St Mary's</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Rural Hollywood</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits write RURAL and give nearest town) <b>TOWN Rural Hollywood</b> <b>X</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <b>James Manning Bassford</b>				4. DATE OF DEATH <b>Feb. 7, 1956</b>			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH: <b>Nov. 20, 1925</b>	
9. AGE last birthday: <b>30</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Storekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>U.S. Navy</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME: <b>William Francis Bassford Sr.</b>		14. MOTHER'S MAIDEN NAME: <b>Annie Ruth Norris</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b>		16. SOCIAL SECURITY No.: <b>219-16-0244</b>		17. INFORMANT & ADDRESS: <b>William F. Bassford Hollywood, Md.</b>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <b>Asphyxia</b>					
DUE TO					
Antecedent cause(s) (b) <b>Drinking</b>					
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none</b>					
19a. DATE OF OPERATION: <b>none</b>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY <b>Patients' Rd</b>		21c. (City or town) (County) (State) <b>Hollywood, St. Mary's, Md.</b>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>18 2 7 56 10:10 M.</b>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Bassford</b>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <b>W. F. Bassford</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>2/4/56</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>2/14/56</b>		NAME OF CEMETERY OR CREMATORY <b>St John's</b>	
LOCATION (City, town, or county) (State) <b>Hollywood, Maryland</b>		24. FUNERAL DIRECTOR ADDRESS <b>Charles J. Mattingly Leonardtown, Md.</b>			
DATE REC'D BY LOCAL REG. <b>2/14/56</b>		REGISTRAR'S SIGNATURE <b>Charles J. Mattingly</b>			

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
FEB 16 1956  
BUREAU V. 3

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 18 Film G195 4-19-56 ams

02135

## 2141 CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ST. MARYS</b>		STATE <b>MARYLAND</b>		COUNTY <b>ST. MARYS</b>			
CITY OR TOWN <b>LEONARDTOWN</b>		LENGTH OF STAY (in this place)		CITY OR TOWN <b>MECHANICSVILLE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>ST. MARYS HOSPITAL</b>				STREET ADDRESS <b>RURAL</b>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <b>SARAH</b>		(Middle) <b>ZOOK</b>		(Last) <b>BEILER</b>		(Month) (Day) (Year) <b>2 - 10 - 1956</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>		8. DATE OF BIRTH <b>6/17/1944</b>	
9. AGE last birthday <b>11</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>SAMUEL Y. BEILER</b>		14. MOTHER'S MAIDEN NAME <b>NANCY ZOOK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT & ADDRESS <b>SAMUEL Y. BEILER - MECHANICSVILLE, MD.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
193X IMMEDIATE CAUSE (A) <b>NEOPLASM - BRAIN ?</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>FINAL DIAGNOSIS DEPENDANT ON POST MORTEM ANALYSIS OF BRAIN</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Hydrocephalus, internal, obstructive, due to glioma</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>FEB 10, 1956</u> <b>to</b> <u>FEB 10, 1956</u> <b>that I last saw the deceased alive on</b> <u>FEB 10, 1956</u> <b>and that death occurred at</b> <u>1149</u> <b>M, from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>JR. [Signature]</u> <b>M.D.</b> <u>MECHANICSVILLE, MD 2/13/56</u> <b>DATE SIGNED</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>2/14/56</b>		NAME OF CEMETERY OR CREMATORY <b>AMISH CEMETERY</b>		LOCATION (City, town, or county) (State) <b>MECHANICSVILLE, MD.</b>	
24. REC'D BY REGISTRAR <b>2/16/56</b>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <b>LEONARDTOWN, MD.</b>	



RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02136

## 2142 CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>ST. MARYS</b>		STATE <b>MARYLAND</b>		COUNTY <b>ST. MARYS</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>LEONARDTOWN</b>				TOWN <b>RIVER SPRING</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>ST. MARYS HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>RURAL</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>WALTER RAYNER BLAIR</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>2 - 13 - 1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>12 - 13 - 1903</b>	9. AGE last birthday <b>52</b> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM OWNER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM BLAIR</b>				14. MOTHER'S MAIDEN NAME <b>BERTHA MC CAULEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT & ADDRESS <b>MARY G. BLAIR * RIVER SPRING, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>420.1</b>				<b>Coronary Thrombosis</b>		<b>5 hrs</b>	
ANTECEDENT CAUSE(S) DUE TO				<b>Arterio sclerotic C.V. disease</b>		<b>8 yrs</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec 13, 1953</b> , to <b>Feb 13, 1956</b> , that I last saw the deceased alive on <b>Feb 13, 1956</b> and that death occurred at <b>5:30</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Ray Guyther</b>				ADDRESS (Street, city, town, state) <b>Mechanicsville, Md</b> DATE SIGNED <b>2/14/56</b>			
23. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		DATE THEREOF <b>2 - 16 - 56</b>		NAME OF CEMETERY OR CREMATORY <b>ALL SAINTS CEMETERY</b>		LOCATION (City, town, or county) (State) <b>OAKLEY, MARYLAND</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <b>Alan S. Hawes</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson</b>		ADDRESS <b>LEONARDTOWN, Md.</b>	
DATE <b>2/16/56</b>							

FEB 17 1956

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2143

02137

Reg. Dist. No. 282

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>ST. MARYS</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNT <b>Charles</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>LEONARDTOWN</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>ROCK POINT</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>ST. MARYS HOSPITAL</b>				STREET ADDRESS (If rural, give location) <b>RURAL</b>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <b>BARBARA</b>		(Middle) <b>ANN</b>		(Last) <b>BOARMAN</b>		(Month) (Day) (Year) <b>2 - 5 1956</b>	
5. SEX: <b>female</b>		6. COLOR OR RACE: <b>white</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>		8. DATE OF BIRTH: <b>Nov. 14, 1938</b>	
9. AGE last birthday: <b>17</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>student</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>School</b>		11. BIRTHPLACE (State or foreign country): <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME: <b>John W. Boarman</b>			
14. MOTHER'S MAIDEN NAME: <b>Ida C. Shorter</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY No.: -----				17. INFORMANT & ADDRESS: <b>John W. Boarman - Rock Point, Md.</b>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>Fractured skull</b> DUE TO						mediate	
Antecedent cause(s) (b) <b>fracture</b> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <b>Fractured cervical spine.</b>							
19a. DATE OF OPERATION: <b>none</b>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office, etc.) <b>3455 Highway Leonardtown, St. Marys, Md</b>		21c. City or town (County) (State) <b>Leonardtown, St. Marys, Md</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>2 5 56 8:15 P.M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Car turned over</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>John W. Boarman</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <b>2/5/56</b>					
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>2/8/56</b>		NAME OF CEMETERY OR CREMATORY <b>Holy Ghost Cemetery</b>		LOCATION (City, town, or county) (State) <b>Issue, Md.</b>	
DATE REC'D BY LOCAL REG. <b>2/6/56</b>		REGISTRAR'S SIGNATURE <b>John W. Boarman</b>		24. FUNERAL DIRECTOR <b>Archart Funeral Home, Inc. La Plata, Md.</b>			
				ADDRESS <b>La Plata, Md.</b>			

BUREAU V. S.

FEB 8 1956

RECEIVED

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INSTRUCTIONS

**1** executed within **24 hours** after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2144 **CERTIFICATE OF DEATH**

02138

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>St Mary's</u>		STATE <u>Maryland</u>		COUNTY <u>St Mary's</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Hermanville</u>		<u>12 Yrs</u>		TOWN <u>Hermanville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>John</u> (Middle) <u>Henry</u> (Last) <u>Clayton</u>				Feb. <u>13</u> , 19 <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Colored</u>	<u>Widowed</u>	<u>June 26, 1877</u>	<u>78</u> yrs.	Months <u>7</u> Days <u>18</u>	Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpender</u>		<u>Day Labor</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Clayton</u>				<u>Sophia Swann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Mrs Fessie Biscoe 15 Van Buren St.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 10, 1952</u> , to <u>Feb 13, 1956</u> , that I last saw the deceased alive on <u>Feb 11, 1956</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>P. W. Swann</u>				ADDRESS (Street, city, town, state) <u>Realtor M. M. M.</u>		DATE SIGNED <u>2/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/15/56</u>		<u>Zion Fair</u>		<u>Hermanville, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2/13/56</u>		<u>P. W. Swann</u>		<u>Charles J. Mattingley</u>		<u>Leonardtown, Md.</u>	

# CERTIFICATE OF DEATH

1. Name of deceased: *John Henry Jones*

2. Sex: *Male*

3. Date of birth: *Jan 15, 1895*

4. Place of birth: *St. Louis, Mo.*

5. Race: *White*

6. Occupation: *Farmer*

7. Usual residence: *123 Main St., Baltimore, Md.*

8. Date of death: *Feb 10, 1956*

9. Time of death: *10:30 AM*

10. Cause of death: *Heart Disease*

11. Manner of death: *Natural*

12. Signature of physician: *Dr. J. H. Smith*

13. Signature of registrar: *John Doe*

14. Signature of informant: *John Doe*

15. Signature of medical examiner: *Dr. J. H. Smith*

16. Signature of coroner: *John Doe*

17. Signature of funeral director: *John Doe*

18. Signature of undertaker: *John Doe*

19. Signature of cemetery: *John Doe*

20. Signature of burial place: *John Doe*

21. Signature of interment: *John Doe*

22. Signature of final disposition: *John Doe*

23. Signature of final disposition: *John Doe*

24. Signature of final disposition: *John Doe*

25. Signature of final disposition: *John Doe*

26. Signature of final disposition: *John Doe*

27. Signature of final disposition: *John Doe*

28. Signature of final disposition: *John Doe*

29. Signature of final disposition: *John Doe*

30. Signature of final disposition: *John Doe*

31. Signature of final disposition: *John Doe*

32. Signature of final disposition: *John Doe*

33. Signature of final disposition: *John Doe*

34. Signature of final disposition: *John Doe*

35. Signature of final disposition: *John Doe*

BUREAU V. S.

FEB 15 1956

RECEIVED

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2145  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03241  
Reg. Dist.

No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>St Mary's</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>St Mary's</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X TOWN Helen</b>		LENGTH OF STAY (in this place) <b>5 Months</b>		CITY (If outside corporate limits write RURAL and give nearest town) <b>TOWN Helen</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Lloyd William Copsey</b>				4. DATE OF DEATH <b>Feb. 27, 19 56</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Aug. 31, 1910</b>	9. AGE last birthday: <b>45</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Day Labor</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Wilson Copsey</b>				14. MOTHER'S MAIDEN NAME: <b>Cora Greenwell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>220-07-4151</b>		17. INFORMANT & ADDRESS: <b>Mrs Ruth Maie Copsey Helen, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <b>Pneumonia, bullet wound of head</b> DUE TO Antecedent cause(s) (b) <b>none</b> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<b>immediate</b>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <b>none</b>				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <b>Home</b>		21c. (City or town) (County) (State) <b>Helen St. Mary's Md</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>2 27 56 9 A.M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>self inflicted bullet wound</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>[Signature]</b>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <b>2/28/56</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>3/2/56</b>		NAME OF CEMETERY OR CREMATORY <b>St John's</b>		LOCATION (City, town, or county) (State) <b>Hollywood Md</b>	
DATE REC'D BY LOCAL REG. <b>2/29/56</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>Leonardtown, Md.</b>	



RECEIVED

MAR 1 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2146

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02139

Reg. Dist.

No. 282

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>SS. MARY'S</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>ST. MARY'S</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>RURAL RIDGE</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <b>RIDGE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) <b>ERNEST</b>		(Middle) <b>MATTHEW</b>		(Last) <b>FORREST</b>		4. DATE OF DEATH <b>FEB. 8,</b> 19 <b>56</b>	
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH: <b>May 5, 1902</b>	9. AGE last birthday: <b>53</b> yrs.	IF UNDER 1 YEAR Months <b>9</b> Days <b>3</b>		IF UNDER 24 HRS. Hours <b>3</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>John W. Forrest</b>				14. MOTHER'S MAIDEN NAME: <b>Elizabeth Ridgell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <b>Jeanette A. Forrest Ridge, Maryland</b>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH.
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>Immediate cause (a) <b>Asphyxia due to Drowning</b></p> <p>DUE TO</p> <p>Antecedent cause(s) (b)</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO</p> <p>stating underlying cause last (c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none except confusion of head.</b>							
19a. DATE OF OPERATION: <b>none</b>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <b>Creek</b>		21c. (City or town) <b>Ridge</b> (County) <b>St. Mary's</b> (State) <b>MD</b>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>2 5 56 P.M.</b>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Fell into creek</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>[Signature]</b>		M. D. <b>[Signature]</b>		CHIEF MEDICAL EXAMINER		DATE SIGNED <b>2/11/56</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>2/11/56</b>		NAME OF CEMETERY OR CREMATORY <b>TRINITY</b>		LOCATION (City, town, or county) (State) <b>ST MARY'S CITY, MD.</b>	
DATE REC'D BY LOCAL REG. <b>2/19/56</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>CHARLES J. MATTINGLY</b>		ADDRESS <b>LEONARDTOWN, MD.</b>	

RECEIVED  
FEB 10 1956  
BUREAU V. S.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02140

## 2147 CERTIFICATE OF DEATH

Reg. Dist. No. 282

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <b>Leonardtwn</b>		<b>10 days</b>		TOWN <b>Rural Leonardtown</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St Mary's Hospital</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>James Ernest Johnson</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Feb. 17, 1956</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 28, 1881</b>		<b>9. AGE last birthday</b> <b>74 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <b>8</b> Days <b>20</b>	<b>IF UNDER 24 HRS.</b> Hours <b>20</b> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Farming</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Tenant</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Hillary Johnson</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie M. Thompson</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>220 34 4324</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Ernest H. Johnson Leonardtown, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
158X IMMEDIATE CAUSE (A) <b>Uremia</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Invasive carcinoma</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <b>retroperitoneal-involving renal system</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Feb 7, 1956, to Feb 17, 1956, that I last saw the deceased alive on Feb 17, 1956, and that death occurred at 7:15 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Ray E. Gwyther</i>		<b>M.D.</b> <i>W. E. Hancock</i>		<b>ADDRESS</b> (Street, city, town, State) <i>Morganza, Maryland</i>		<b>DATE SIGNED</b> <i>2/17/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>2/20/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St Joseph</b>		<b>LOCATION (City, town, or county)</b> (State) <b>Morganza, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Alan R. Haynes M.D.</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Charles J. Mattingly</i>			
<b>DATE</b> <b>2/22/56</b>				<b>ADDRESS</b> <b>Leonardtwn, Md.</b>			

Bough.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

## CITY CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Date of Death [Illegible]	
Place of Birth [Illegible]		Age [Illegible]	
Sex [Illegible]		Race [Illegible]	
Occupation [Illegible]		Cause of Death [Illegible]	
Medical History [Illegible]		Burial Place [Illegible]	
Signature of Physician [Illegible]		Signature of Registrar [Illegible]	

RECEIVED

BUREAU V. S.

FEB 24 1936



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must be filled in by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2148

## CERTIFICATE OF DEATH

02141

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <b>St Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>			
c. LENGTH OF STAY IN 1b <b>1 day</b>				d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>78 St Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Lacey</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 23, 1956</b>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles P. Lacey</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ann Lacey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles P. Lacey</b> Address <b>Leonardtown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity (5 mo., gestation)</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/24</b> , 19 <b>56</b> to <b>2/24</b> , 19 <b>56</b> that I last saw the deceased alive on <b>2/24</b> , 19 <b>56</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mechanicville</b> DATE SIGNED <b>Hean W. Benby</b>							
ACTUAL SIGNATURE <b>Hean W. Benby</b> M.D.							
PHYSICIAN'S NAME (Type) <b>J. Roy Guyther M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/25/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St Aloysius</b>		22d. LOCATION (City, town, or county) (State) <b>Leonardtown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Mattingly</b>				ADDRESS <b>Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>2/28/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Hean W. Benby, M.D.</b>			

2078193220

# CERTIFICATE OF DEATH

2118

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
RACE [Illegible]		OCCUPATION [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CORONER [Illegible]		SIGNATURE OF REGISTRAR [Illegible]	
CERTIFICATE OF DEATH [Illegible]		CERTIFICATE OF DEATH [Illegible]		CERTIFICATE OF DEATH [Illegible]	

BUREAU V. S.

FEB 29 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02142

## 2149 CERTIFICATE OF DEATH

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ST Mary's</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>St Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>NAS PATUXENT RIVER, MARYLAND</b>		LENGTH OF STAY (in this place) <b>31 hours</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park, Niagara Falls</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U.S. Naval Air Station Hospital Patuxent River, Maryland</b>				STREET ADDRESS (If rural give location) <b>290 Chinlee Drive 304 79th St.</b>			
<b>3. NAME OF DECEASED</b> (First) <b>Kim</b> (Middle) <b>Aldea</b> (Last) <b>LANSKY</b>				<b>4. DATE OF DEATH</b> (Month) <b>Feb</b> (Day) <b>17</b> (Year) <b>19 56</b>			
<b>5. SEX</b> <b>F</b>	<b>6. COLOR OR RACE</b> <b>Caucasian</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>16 Feb 1956</b>		<b>9. AGE last birthday</b> Yrs. <b>1</b> Months <b>1</b> Days <b>7</b> Hours <b>36</b> Mjn.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) -----		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> -----		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Theodore S. LANSKY</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Mildred STEWART</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) ----- (If Yes, give war or dates of service) -----		<b>16. SOCIAL SECURITY NO.</b> -----		<b>17. INFORMANT &amp; ADDRESS</b> <b>Theodore LANSKY</b> <b>290 Chinlee Drive, Lexington, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>751X</b> IMMEDIATE CAUSE (A) <b>PREMATURITY 32 Weeks Gestation</b>						INTERVAL BETWEEN ONSET AND DEATH <b>31 hours</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Atelectasis</b>						<b>31 hours</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Meningocele lumbar spine</b>						<b>31 hours</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> -----		<b>19b. MAJOR FINDINGS OF OPERATION</b> -----					
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.) -----		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) ----- (County) ----- (State) -----			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) -----		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> -----			
<b>22. I hereby certify that I attended the deceased from 16 Feb 1956, to 17 Feb 1956, that I last saw the deceased alive on 17 Feb 1956, and that death occurred at 2:02 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>R. Spiekerman MC USNR</b>				<b>ADDRESS</b> (Street, city, town, state) <b>U.S. Naval Air Station Hospital Patuxent River, Maryland</b>			
<b>DATE SIGNED</b> <b>17 Feb 1956</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>22 Feb 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Holy Face</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Great Mills, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>A-22-56</b>		<b>REGISTRAR'S SIGNATURE</b> <b>PJ Bean, MD.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Father Lane</b>		<b>ADDRESS</b> <b>Patuxent River</b>	

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

## DEATH CERTIFICATE

Form No. 10

1. Name of deceased (Print or write)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Date of death (Month, Day, Year)

6. Time of death (Hour, Minute)

7. Cause of death (Print or write)

8. Place of death (City, State, Country)

9. Signature of physician (Print or write)

10. Signature of registrar (Print or write)

11. Signature of informant (Print or write)

12. Signature of witness (Print or write)

13. Signature of witness (Print or write)

14. Signature of witness (Print or write)

15. Signature of witness (Print or write)

16. Signature of witness (Print or write)

17. Signature of witness (Print or write)

18. Signature of witness (Print or write)

19. Signature of witness (Print or write)

20. Signature of witness (Print or write)

21. Signature of witness (Print or write)

22. Signature of witness (Print or write)

23. Signature of witness (Print or write)

24. Signature of witness (Print or write)

25. Signature of witness (Print or write)

26. Signature of witness (Print or write)

27. Signature of witness (Print or write)

28. Signature of witness (Print or write)

29. Signature of witness (Print or write)

30. Signature of witness (Print or write)

31. Signature of witness (Print or write)

32. Signature of witness (Print or write)

33. Signature of witness (Print or write)

34. Signature of witness (Print or write)

35. Signature of witness (Print or write)

36. Signature of witness (Print or write)

37. Signature of witness (Print or write)

38. Signature of witness (Print or write)

39. Signature of witness (Print or write)

40. Signature of witness (Print or write)

BUREAU V. S.

FEB 24 1956

RECEIVED

NOT TO BE REPRODUCED

This certificate is to be filled out by the physician or other qualified person who attended the deceased or who was present at the time of death. It should be filled out as soon as possible after death and should be filed in the office of the registrar of vital statistics. It is a legal document and its contents are subject to the laws of the State of Maryland. It is not to be used for any other purpose.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 21 Film G193 3-13-56 ams

02143

2150

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>St. Mary's</b>		STATE <b>Maryland</b>		COUNTY <b>St. Mary's</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Leonardtown, Md.</b>		<b>2 months</b>		TOWN <b>Ridge, Md.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St. Mary's Hospital Leonardtown, Md.</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Ebbie Mary Lee</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Feb. 24, 1956</b>			
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>colored</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>July 22, 1879</b>		<b>9. AGE last birthday</b> <b>76 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Domestic</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>St. Mary's County, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>America</b>	
<b>13. FATHER'S NAME</b> <b>Randolf Clinton</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Fade</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>-----</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Joseph J. Lee - Hermansville, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>916.0 IMMEDIATE CAUSE (A)</b> <b>Myocarditis</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 yrs.</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Severe third degree burns</b>						<b>2 mos.</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <b>Home Home</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b> <b>Ridge St. Marys Md.</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <b>12-18-55 M.</b>		<b>21a. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b> <b>Lamp fell over &amp; caught dress on fire.</b>			
<b>22. I hereby certify that I attended the deceased from Dec. 18, 1955, to Feb. 24, 1956, that I last saw the deceased alive on Dec. 24, 1956, and that death occurred at 9 M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>John H. Patrick</i>		<b>DATE THEREOF</b> <b>2/28/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>St. Peters</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Ridge, Maryland</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>24. REC'D BY REGISTRAR</b> <b>Alan D. Houser</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Robinson</i>		<b>DATE SIGNED</b> <b>2-27-56</b>	
<b>DATE</b> <b>3/1/56</b>		<b>Leonardtown, Md.</b>					





2151

02144

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 282

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <b>ST Mary's</b>	MARYLAND		STATE <b>Maryland</b>	COUNTY <b>ST. Mary's</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Piney Point</b>	LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits write RURAL and give nearest town) <b>Piney Point</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED: (Type or Print)			4. DATE OF DEATH		
(First) <b>Joseph</b>	(Middle) <b>Austin</b>	(Last) <b>Morgan</b>	(Month) <b>Feb.</b>	(Day) <b>10,</b>	(Year) <b>19 56</b>
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Caucasian</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>June 7, 1880</b>		
9. AGE last birthday: <b>75</b> yrs.			10. IF UNDER 1 YEAR: <b>8</b> Months <b>5</b> Days <b>5</b> Hours <b>10</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Caretaker</b>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME: <b>Daniel Morgan</b>			14. MOTHER'S MAIDEN NAME: <b>Patsy Seldon</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY No.: <b>No</b>	17. INFORMANT & ADDRESS: <b>Daniel Morgan Piney Point, Md.</b>		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
450.0 Immediate cause (a) <b>Coronary Heart Failure</b> DUE TO			<b>1 month</b>		
Antecedent cause(s) (b) <b>Arteriosclerosis</b> Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none</b>					
19a. DATE OF OPERATION: <b>none</b>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <b>none</b>	21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>none</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>none</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <b>[Signature]</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>2/11/56</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF: <b>2/13/56</b>	NAME OF CEMETERY OR CREMATORY: <b>St. Marks</b>		LOCATION (City, town, or county) (State): <b>Valley Lee, Maryland</b>	
DATE REC'D BY LOCAL REG.: <b>2/14/56</b>	REGISTRAR'S SIGNATURE: <b>[Signature]</b>		24. FUNERAL DIRECTOR: <b>Charles J. Mattingly Leonardtown, Md.</b>		

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 16 1956

BUREAU V. 1

2152

## CERTIFICATE OF DEATH

Reg. Dist. No.

284

1. PLACE OF DEATH o. COUNTY <b>St Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X St George Island</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St George Island</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MD</b>				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) <b>Hattie Ann Potter</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1873</b>	9. AGE (In years last birthday) yrs. <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Venerando Sayre</b>				14. MOTHER'S MAIDEN NAME <b>Virginia L. Scott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mr Vennie M. Potter Great Mills, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral sclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General arteriosclerosis</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 19 35</b> , to <b>Feb 24</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Feb 23</b> , 19 <b>56</b> , and that death occurred at <b>12:10 PM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>P. J. Bean</b>				ADDRESS (Street, city or town, state) <b>Great Mills, Md.</b>		DATE SIGNED <b>2/24/56</b>	
PHYSICIAN'S NAME (Type) <b>P. J. Bean M.D.</b>				Great Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27/56</b>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>St George Island, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Mattingley</b>				ADDRESS <b>Leonardtwn, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>2/24/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>P. J. Bean</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

FEB 28 1956

RECEIVED



2153 **CERTIFICATE OF DEATH**Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>ST. MARYS</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>ST. MARYS</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>DAMERON</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>DAMERON</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>RURAL</b>				STREET ADDRESS (If rural give location) <b>RURAL</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>WILLIAM CALVERT RALEY</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>2 - 12 - 19 56</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>MARRIED</b>	<b>8. DATE OF BIRTH</b> <b>12 - 8 - 1882</b>	<b>9. AGE last birthday</b> <b>73</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>FARM OWNER</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>WILLIAM WALTER RALEY</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>LAURA VIRGINIA RALEY</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> -----		<b>17. INFORMANT &amp; ADDRESS</b> <b>DORTHY M. RALEY - RIDGE, MARYLAND</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>421.4 IMMEDIATE CAUSE (A)</b> <u>Vascular Heart Disease</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 years</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>STATING UNDERLYING CAUSE LAST. DUE TO</b>							
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not white <input type="checkbox"/> et work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from May 1950, to Feb 12 1956, that I last saw the deceased alive on Feb 11, 1956, and that death occurred at 13 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>P. B. Robinson</i>		<b>M.D.</b> <i>P. B. Robinson</i>		<b>ADDRESS (Street, city, town, state)</b> <i>2113 1/2 St. N. LEONARDTOWN, MD.</i>		<b>DATE SIGNED</b> <i>2/13/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>BURIAL</b>		<b>DATE THEREOF</b> <b>2/15/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>ST. MICHAELS CEMETERY</b>		<b>LOCATION (City, town, or county) (State)</b> <b>RIDGE, MARYLAND</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <i>2/13/56</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Local Registrar</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>P. B. Robinson</i>		<b>ADDRESS</b> <b>LEONARDTOWN, MD.</b>	

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

1956

File No. 100

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, town, village, or foreign country)

5. Usual residence (Street, city, town, village, or foreign country)

6. Date of death (Month, day, year)

7. Time of death (Hour, minute)

8. Cause of death (Immediate cause, underlying cause, and contributing causes)

9. Manner of death (Natural, accident, suicide, homicide, or undetermined)

10. Signature of attending physician (Print name and sign)

11. Signature of medical examiner (Print name and sign)

12. Signature of registrar (Print name and sign)

13. Signature of informant (Print name and sign)

14. Signature of funeral director (Print name and sign)

15. Signature of coroner (Print name and sign)

16. Signature of justice of the peace (Print name and sign)

17. Signature of health officer (Print name and sign)

18. Signature of registrar (Print name and sign)

19. Signature of informant (Print name and sign)

20. Signature of funeral director (Print name and sign)

21. Signature of coroner (Print name and sign)

22. Signature of justice of the peace (Print name and sign)

23. Signature of health officer (Print name and sign)

24. Signature of registrar (Print name and sign)

25. Signature of informant (Print name and sign)

26. Signature of funeral director (Print name and sign)

27. Signature of coroner (Print name and sign)

28. Signature of justice of the peace (Print name and sign)

29. Signature of health officer (Print name and sign)

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, town, village, or foreign country)

5. Usual residence (Street, city, town, village, or foreign country)

6. Date of death (Month, day, year)

7. Time of death (Hour, minute)

8. Cause of death (Immediate cause, underlying cause, and contributing causes)

9. Manner of death (Natural, accident, suicide, homicide, or undetermined)

10. Signature of attending physician (Print name and sign)

11. Signature of medical examiner (Print name and sign)

12. Signature of registrar (Print name and sign)

13. Signature of informant (Print name and sign)

14. Signature of funeral director (Print name and sign)

15. Signature of coroner (Print name and sign)

16. Signature of justice of the peace (Print name and sign)

17. Signature of health officer (Print name and sign)

18. Signature of registrar (Print name and sign)

19. Signature of informant (Print name and sign)

20. Signature of funeral director (Print name and sign)

21. Signature of coroner (Print name and sign)

22. Signature of justice of the peace (Print name and sign)

23. Signature of health officer (Print name and sign)

24. Signature of registrar (Print name and sign)

25. Signature of informant (Print name and sign)

26. Signature of funeral director (Print name and sign)

27. Signature of coroner (Print name and sign)

28. Signature of justice of the peace (Print name and sign)

29. Signature of health officer (Print name and sign)

BUREAU V. S.

FEB 15 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2154

## CERTIFICATE OF DEATH

02147

Reg. Dist. No. 281

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Leonardtwn</u>				TOWN <u>Damerón</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Marys Hospital</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Thomas</u> <u>Richardson</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>2</u> - <u>17</u> - <u>56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>5 - 2 - 1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Richardson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Brady</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Mary E. Smith- St. Inigoes, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A) <u>Coronary sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>General arteriosclerosis</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Oct 8, 1957</u> , to <u>Feb 17, 1956</u> , that I last saw the deceased alive on <u>Feb 17, 1956</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Quint Hills Md</u>		DATE SIGNED <u>2/17/56</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michaels</u>		LOCATION (City, town, or county) <u>Ridge, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Feb 19/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>- Leonardtown, Md.</u>	

# CERTIFICATE OF DEATH

2184

W. C. O. L. N. 1

ATTEST: I have examined the record of the deceased

and find that the same is correct and true

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

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W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

W. C. O. L. N. 1

BUREAU V. S.

FEB 24 1956

RECEIVED